DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475032 | A. BUILDING _____ B. WING _____ | C 11/08/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VERMONT VETERANS HOME | 326 NORTH STREET BENNINGTON, VT 05201 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced on-site complaint investigation was completed by staff from the Vermont Division of Licensing & Protection on 11/8/11. The following regulatory violations were identified. | F 000 | Please note that the filing of this plan of correction does not constitute any admission as to any of the alleged violations set forth in this Statement of Deficiency. The POC is being filed as evidence of the facility's continued compliance with all applicable laws. | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance | F 225 | F225<br>Corrective Action:<br>The facility ensures that all allegations of possible resident neglect are reported immediately to the state Survey and Certification Agency.<br><br>Other Residents:<br>All Resident are at risk.<br><br>Systemic Changes:<br>The facility staff have been re-educated on the facility abuse and neglect policy, including reporting requirements (attachment A1)<br><br>Monitoring:<br>The Administrator or Designee will conduct 3 weekly audits, x 60 days, of Accident and Incidents to ensure allegations of abuse and neglect are reported immediately. Audit results will be reported to bimonthly QA meetings. (Attachment A2).<br><br>Compliance Date:<br>December 4, 2011<br><br>F225 POC accepted 12/6/11<br>MBolton RN/PMcotaRN | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa A Jackson — TITLE: Administrator — (X6) DATE: 11/30/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 225 | Continued From page 1<br>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to immediately report an allegation of possible resident neglect to the State survey and certification agency for 1 applicable resident. (Resident #3) Findings include:<br><br>Per review of the facility's mandatory self report for Resident #3 on 11/8/11, the incident of possible neglect of Resident #3 occurred on 9/5/11 at 1630 hours and was reported to Adult Protective Services (and the State survey and certification agency) via Fax on 9/13/11. "Immediately" is defined by Centers for Medicare and Medicaid Services as not to exceed 24 hours. Vermont Statute requires a report within 48 hours. The late report was confirmed during interview with the DNS on 11/8/11 at 4 PM. | F 225 | **F280**<br>Corrective Action:<br>Resident #2 and #3 care plans have been updated.<br><br>Other residents:<br>All residents are at risk.<br><br>Systemic Changes:<br>1) Clinical Care Coordinators and Nursing Supervisors will be educated on the importance of updating care plans. (Attachment B1)<br>2) The Facility has instituted an I & A/IDT Monitoring form to ensure care plans are updated following an accident and incident. (Attachment B2)<br><br>Monitoring:<br>The DNS or designee will conduct a weekly audit of 5 resident care plans, x 60 days, to ensure the care plans are up to date and accurately reflect the residents care needs. Audits to be reviewed at the bimonthly QA meeting. | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an | F 280 | Compliance Date:<br>December 4, 2011<br><br>F280 POC accepted 12/6/11<br>MBolton RN/ PMcoteRN | |

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| F 280 | Continued From page 2<br>interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the comprehensive care plans for 2 of 7 residents in the applicable sample did not address each resident's current identified/assessed needs. (Residents #2 & #3 ) Findings include:<br><br>Per record review on 11/8/11, the care plans for Residents #2 and #3 failed to address all of their current needs as follows:<br><br>a. Resident #2 - The resident (who had short term memory issues and was medically complex) had a history of leaving the facility grounds without signing out or informing staff first, presenting a potential safety hazard, and there was no care plan to address this need and monitor his/her whereabouts.<br><br>b. Resident #2 - The resident was found with a lighted candle on the walker in their room on 11/2/11 and there was no care plan to address the safety concerns regarding the resident's potentially unsafe action. | F 280 | | |

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| F 280 | Continued From page 3<br><br>The lack of care planning for these problems was confirmed during interviews with the staff nurse at 2:45 PM and the DNS (Director of Nursing Services) at 4:30 PM on 11/8/11.<br><br>c. Resident #3 - The care plan for Resident #3, who had sustained a fractured ankle during a wheelchair transport by a LNA, included use of a 'knee immobilizer at all times' and 'air cast left foot at all times'. Per review on 11/8/11, a physician order dated 10/28/11 at 1237, stated "discontinue left knee immobilizer and air cast left foot". The care plan was not revised to reflect the discontinuation of these devices on 10/28/11. This was confirmed during interview with the Clinical Care Coordinator (CCC) on 11/8/11 at 12:20 PM. | F 280 | **F281**<br>Corrective Action:<br>The facility ensures that podiatry services are provided for all Residents with diabetes and all other Residents as needed.<br><br>Other Residents:<br>All Residents are at risk<br><br>Systemic Changes:<br>1) Chart audits will be conducted to determine if there are other Residents who require Podiatry services (Attachment C1).<br>2) The CCC's and Nursing Supervisors will be educated on the | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to provide or arrange for podiatry services and failed to follow the standing physician's orders for 1 applicable resident reviewed. (Resident #4). The findings include:<br><br>1. Per review of the closed record for Resident #4, s/he was admitted on 03/31/08 with a diagnosis of diabetes, coronary vascular disease, peripheral vascular disease. The physician's signed standing orders dated May 2008, May | F 281 | Monitoring:<br>The DNS or designee will conduct 5 weekly audits, x 60, days to ensure podiatry services are being provided as ordered. Audit results will be reported at the bimonthly QA meetings.<br><br>Compliance Date:<br>December 4, 2011<br><br>F281 POC accepted 12/6/11<br>MBoltonRN/PMcotaRN | |

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| F 281 | Continued From page 4<br>2009 and June 2010 states 'Podiatry consult for all residents with diabetes...". Per record review, there were no podiatry services provided during a greater than 2 year period from 03/31/08 - 09/29/10 until after the resident developed an ingrown toenail and subsequent infection. Per interview on 11/08/11 at 4:45 PM, the DNS stated that all residents with diabetes are supposed to be checked by the podiatrist at least yearly and confirmed that the physicians orders were not followed and podiatry services were not provided.<br><br>See also F282.<br><br>Reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins, pg 17. | F 281 | **F282**<br><br>Corrective Action:<br>The facility ensures that care plans are implemented as written.<br><br>Other Residents:<br>All Residents are at risk.<br><br>Systemic Changes:<br>Facility Staff have been educated on the facility's policy regarding the refusal of medications, treatments, assessments, and daily care. | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to implement the written plan of care for 1 applicable resident (Resident #4) in the sample. Findings include:<br><br>1. Per review on 11/08/11 of Resident #4's closed record, a care plan for potential for alteration in skin integrity related to diagnosis of diabetes and PVD (peripheral vascular disease) states "weekly skin check by licensed nurse". In | F 282 | Monitoring:<br>The DNS or designee will conduct a weekly audit of 5 Residents, x 60 days, to ensure this policy was followed when care, medications, or treatments were refused. Audit results will be reviewed at bimonthly QA meetings.<br><br>Compliance Date:<br>December 4, 2011<br><br>F282 POC accepted 12/6/11<br>MBolton RN/ DMcotaRN | |

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| F 282 | Continued From page 5<br>addition, the resident also had dementia, anxiety and agitation with care planning to re-approach for refusals and supportive measures. Per review of the weekly skin integrity sheet dated 9/16/10, 9/25/10 and 10/07/10, the skin check was not documented as being completed, with a notation of "refused body audit", with no documentation of further attempts to view skin. Per review of the nursing notes for 10/07/10 the resident developed an open area on the left great toe . Per interview on 11/08/11 at 4:45 PM the DNS stated that the expectation would be that the nursing staff re-approach the resident and to monitor the skin closely especially for a resident who is at risk for skin breakdown. The DNS confirmed that staff did not follow the plan of care.<br><br>See also F281 | F 282 | **F520**<br>Corrective Action:<br>Staff education for the incident involving Resident #3 has been completed. The staff education for the incident involving Resident #1 will take place when the employee returns from an extended leave.<br><br>Other Residents:<br>All Residents are at risk.<br><br>Systemic Changes:<br>The facility has instituted an Event Documentation Checklist to ensure employee education is completed timely. | |
| F 520 SS=D | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee | F 520 | Monitoring:<br>The Administrator or designee will conduct a monthly audit, x 3 months, of all allegations of abuse and/or neglect to ensure staff education was provided as recommended.<br><br>Compliance date:<br>December 4, 2011<br><br>F520 POC accepted 12/6/11<br>MBoltonRN/AMeotaRN | |

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| F 520 | Continued From page 6<br>except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to implement all of the quality measures/plans developed in response to identified quality deficiencies regarding separate incidents involving Residents #3 & #1. Findings include:<br><br>1. Per review of the facility's "Corrective Measures" for Staff on 11/8/11, implemented after a resident sustained a fractured ankle as a result of a LNA's failure to utilize the leg rests as needed for transport of Resident #3 on 9/5/11, the facility stated the following: -All staff members at the Vermont Veterans' Home are being re-educated to reinforce utilizing leg rests while transporting Veterans and members. During interview on 11/8/11 at 4 PM, when asked if all staff had received re-education on the use of leg rests on wheelchairs during transports, the DNS stated that they had started on B Wing (Brandon), and that they had not done re-education for the other units yet. It had been almost 2 months since the accident and all nursing staff were not yet in-serviced as stated in the 'Corrective Measures Plan' submitted to the state as part of the facility's Quality Improvement. In addition, the CCC for the B Wing (Brandon) stated at 12:20 PM on 11/8/11 | F 520 | | |

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| F 520 | Continued From page 7<br>that, although she remembered talking to staff about the leg rests for wheelchairs, she could not find any documented times or dates when the staff were re-educated on this subject.<br><br>2. Per record review, a facility-reported complaint involved 2 nursing staff and a question of whether one or both were yelling at and/or in the presence of Resident #1. The facility's investigative report on the incident, dated 7/28/11 includes:<br>'Action Taken: Staff involved will receive in-service education re: professional conduct.<br>Staff involved will receive in-serviee education re: Resident's rights.<br>Staff involved will receive Supervisory Feedback for unprofessional conduct on Veteran/Member Unit'.<br><br>Per staff interview on 11/8/11 at 3:50 P.M. the facility's Education Director [ED] reported she had not done any in-service education with any staff involved in the 7/28/11 investigative report. ED stated she is not aware of specific investigative reports or in-services related to investigative reports. ED stated that she did not know who would do these education in-services, and stated that the Director of Nursing Services [DNS] would know. Per staff interview on 11/8/11 at 4:05 P.M., the Director of Nursing Services [DNS] reported that in-service education regarding the 7/28/11 investigative report would be done by the DNS or the nursing unit's Clinical Care Coordinator [CCC]. The DNS reported she had not done any in-service education to the staff involved in the 7/28/11 report and was not aware of any education done by the CCC. The DNS stated "I can't say it was done. We don't have any record | F 520 | | |

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| F 520 | Continued From page 8<br>of it." The DNS also stated records of supervisory feedback would be kept on her computer and there is no record of any regarding the 7/28/11 report. | F 520 | | |